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Supporting change management with PRIMIS

Sheila Teasdale MMedSci CompBCS
Service Director, PRIMIS, Division of General Practice, University of Nottingham, UK

ABSTRACT

This paper describes the function of PRIMIS, and its role in supporting change management in primary care, especially with regard to changes brought about by the rapid implementation of information technology in the clinical environment. A number of approaches to managing change and supporting people through change are examined and recommended, and the pitfalls of disregarding a body of knowledge on managing change are demonstrated.

Keywords: change management, clinical information systems, data quality, primary care

What is PRIMIS?

PRIMIS (Primary Care Information Services) was set up in April 2000 to provide a training and support service for information facilitators in primary care.[1] It was commissioned by the Department of Health Information Policy Unit, is funded by the NHS Information Authority (currently until March 2004) and delivered by a team at the University of Nottingham. Its objectives are to help general practices improve patient care by optimising the use of clinical systems, improving the quality of data held in those systems, and improving information management within practices. It is designed to have an impact at practice level, while being based on national and local clinical priorities. It is currently supporting around 250 information facilitators employed in primary care trusts (PCTs) or local health informatics services so that they can help practices to develop information skills and quality data. Of the 304 PCTs in England, 222 are already involved in such work, with another 20 in the planning stage. Data have been extracted from around 3000 practices in order to assess the quality of the data held on their clinical systems, and fed back by the facilitators as the basis of the ensuing education, training and change within participating practices.

How does PRIMIS support change?

The local information facilitators receive training not only in the technical aspects of their work (data quality, clinical coding, MIQUEST, data analysis and interpretation), but also in facilitation skills and change management theory and practice. Otherwise, they would not be in a position to support practices in assessing underlying issues and then helping to plan for and carry out change. The facilitators are taught to take a 'whole system' approach, to help practices assess issues and problems from a multitude of perspectives; they are encouraged to be 'fault tolerant', non-judgmental and flexible in their behaviour. They are also recommended to take an evolutionary approach to change:[2] rather than starting from scratch and implementing completely new systems, success is more likely with an approach of 'If it ain't broke, don't fix it!', that is, building on what works already.[3] PRIMIS facilitators are also advised how to take into account the individual learning styles of all members of the practice team, and how to use the 'adult learning' approach, improving existing skills and involving learners actively in their own education and training programme.[4,5]

How do people respond to change?

Everybody goes through each of the stages, but individuals will progress at different rates dependent upon the change itself and their relationship to it. Examples of typical progression through the stages, when the proposed change is for clinicians in the practice to enter clinical data on to the clinical computer system in the consultation, might be as follows (see Figure 1):

- denial – 'I didn't become a GP to play with computers all day!'
- resistance – 'We will NOT have people coming in here getting into OUR data!'
- exploration – 'Hmmm, wonder what we could do with our data?'
- commitment – 'Of course, our practice manager can now produce monthly reports on the NSFs, because we routinely record clinical data in the consultation.'

Figure 2 demonstrates the speed with which people go through the stages in Figure 1 – for example, the innovators get through to exploration and commitment very quickly. It is necessary to assess where individuals are likely to be in respect of the proposed change and, once that assessment is made, different strategies can be used for the different groups.

- Innovators – people in this group are usually ahead of the proposed change, so need little active help (though sometimes they do need focus).
- Early adopters – these will work with the facilitator and move quite quickly once they get started; they will also be helpful in supporting the majority group.

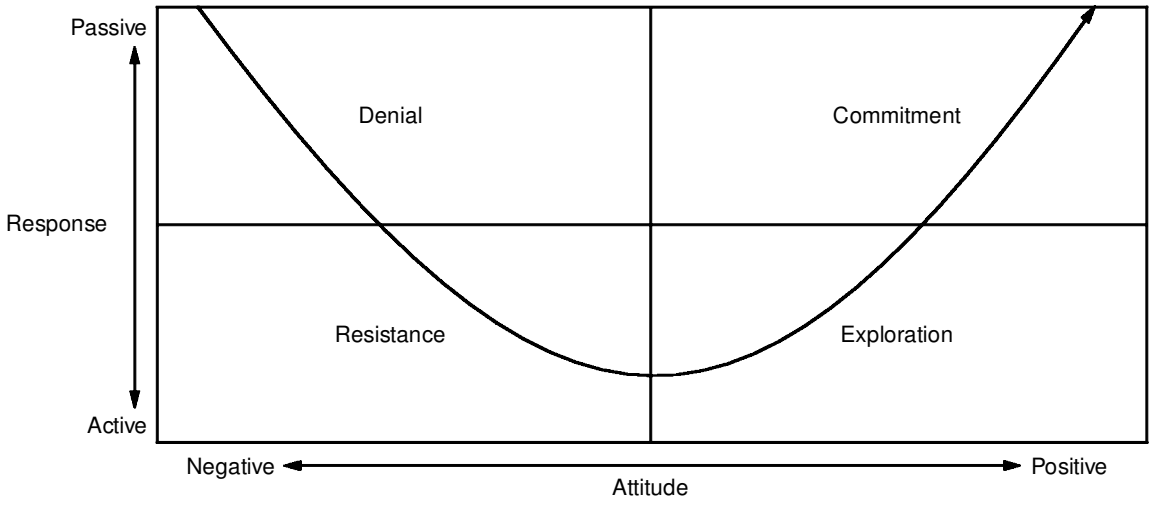

Figure 1 Stages of how people respond to change

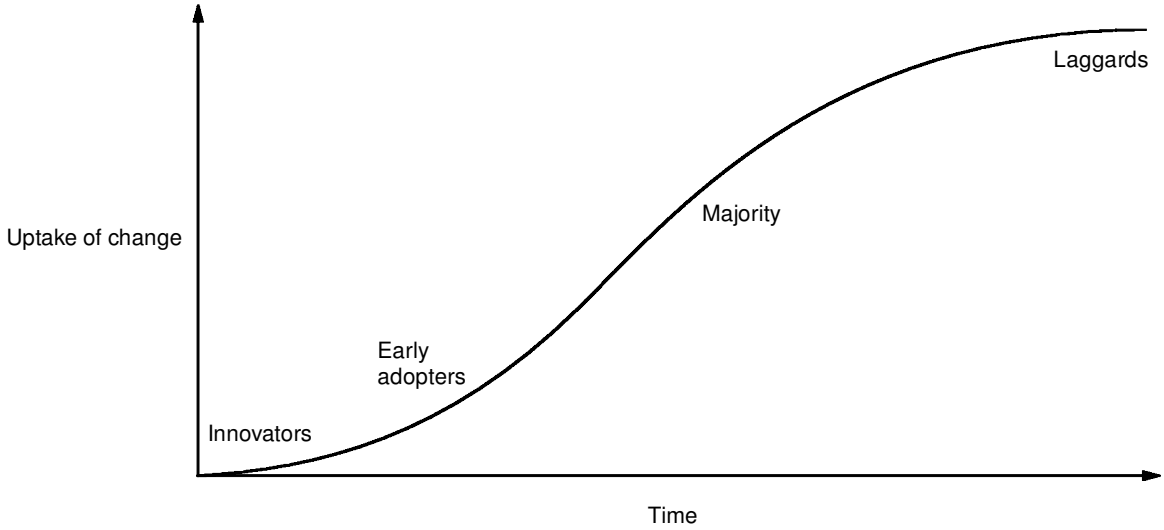

Figure 2 Speed of change

- Majority – people in this group usually need active help once they have decided to make the proposed change, and often respond well to help from peers; in this case those in the early adopter group can be useful.
- Laggards – people in this group tend to get 'stuck' in the denial phase for many changes; usually the facilitator must just wait for them to be ready, and at the very least try to ensure that they do not actively attempt to sabotage the change.

The three stages of managing change

According to Lewin, there are three main stages in managing change, all of which need careful handling.[6]

Stage 1: Unfreezing – reducing resistance to change

The first part of 'unfreezing' is to understand the current situation fully. Traditionally, one might start with defining the problem, and then work through to finding 'the' solution, and then closely defining that. If the problem mapping is not done properly and thoroughly, however, it is too easy to jump to the wrong solution – and even worse is the 'solution in search of a problem' scenario, where a ready-made solution is championed very strongly by one person and agreed on in order to save time. Ultimately, it is more productive to spend time working on defining the whole problem domain (including as many different perspectives as possible); this will usually indicate the general direction in which the solution will be found. You can then go on to defining the 'vision' (not 'the solution' yet) and map that in broad terms. This vision must be shared by all those involved in the proposed change; finally, it will be possible to work backwards from where you want to be, which will help produce a 'gap analysis' to define the general areas of change needed and the direction of travel in order to achieve the new vision.

The second part of 'unfreezing', establishing the need to change, can run concurrently with the first. A useful way of doing this is to carry out a force-field analysis: for every change there are driving and resisting forces and, for the change to be successful, the driving forces need to be stronger than the resisting forces. The driving forces are often present in the environment and are not amenable to alteration, but the resisting forces need to be lessened. An example is given in Figure 3.

The third phase of 'unfreezing', raising dissatisfaction, is often overlooked but is particularly important; if a person or group is happy with the current situation, it will be very difficult to get them to change without some motivation. In-depth exploration may be necessary, involving the whole team in diagnosing the current situation, thereby gaining ownership of the problem. A powerful technique is to ask those involved to predict the effects over one or two years of maintaining the status quo. For example: 'When the new GP contract is introduced next year, how will your practice in its current state be able to report on activities in order to qualify for quality payments?' Once the level of dissatisfaction has been raised, it is necessary to create a shared vision of a better future, and devise some clear

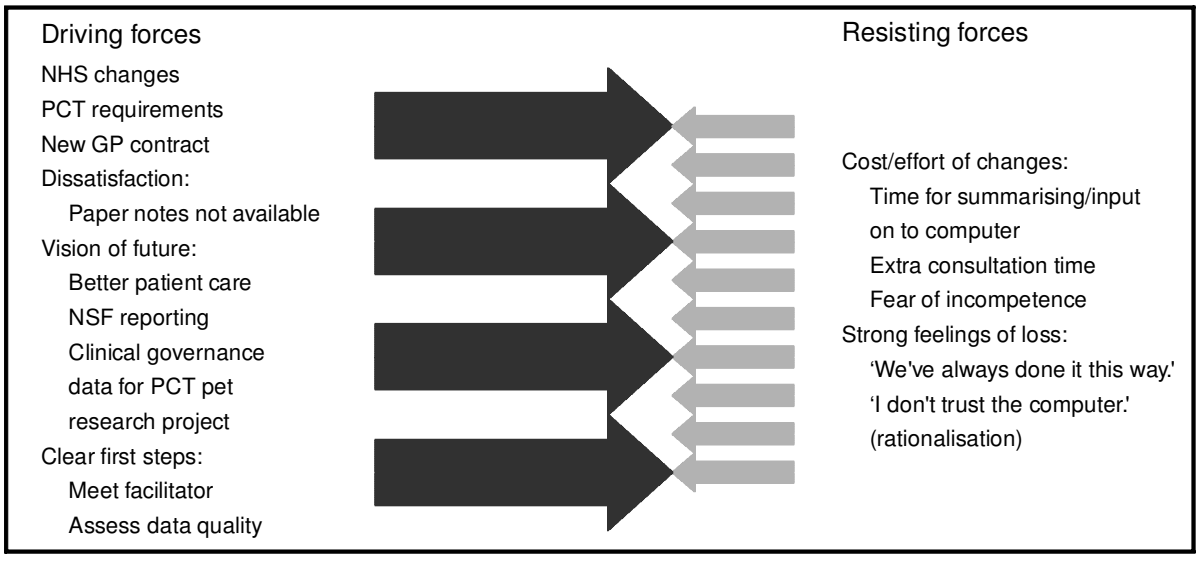

Figure 3 Force-field analysis example for using the computer in the consultation

and safe first steps to making the change envisaged. Again, these are shown as part of the driving forces in the example in Figure 1.

The final part of the 'unfreezing' process is to consult and communicate widely with all those involved in making the proposed changes. This will run right through from the beginning of the process.

Stage 2: Changing – implementing the new procedures or methods of operation

The need for communication is important throughout this phase also: a variety of methods can be used, such as product champions or peer pressure, as well as the usual written communications or meetings. Once the need for change is recognised and agreed, it is time to devise detailed plans and targets – and these must be agreed with all those involved in the change. A training needs analysis for all members of the practice team should be carried out so that they are enabled to cope with the proposed change, and an agreed training plan should be implemented, tailored to the individual needs and learning styles of each team member. These training needs should be met in advance of implementing the change, thus enhancing 'comfort' in the new situation. For example, providing training in the use of a clinical system in the consultation for a GP or a nurse will help them be (and feel) competent with the new technology in the patient's presence – this will enhance the confidence of the patient also.

Legitimate feelings of loss must be respected, and worked through (again, this will happen at different speeds for different individuals).

- Loss of security: a GP may feel that someone else is the expert in the area of information, so there may be feelings of loss of control, gaps in knowledge, changes in status, lack of confidence, fear of loss of credibility, and so on.
- Lack of competence: many team members will need to learn new skills, and there is a consequent (though temporary) decrement in performance while learning.
- Changes in relationships: new working relationships will need to be worked out as tasks and workflows change.
- Loss of sense of direction: this happens especially when the changes are imposed from elsewhere, and leads to feeling rudderless and powerless to affect the future – classic symptoms of depression.
- Loss of territory: changes in work practices, tasks and workflows often lead to changes in the physical environment – people may have to move to a new office or workspace – and also changes in the psychological environment. People fear losing tasks with which they are familiar and in which they are competent, and frequently fear that they will lose their jobs altogether: a particular example is the fear of the reception staff in a practice going 'paperless' that a large part of their job, pulling and replacing paper records, will disappear.

Monitoring during change

While any change is taking place, it is important to monitor progress. However, this is not to say that slavish adherence to the original plan is mandatory! Such monitoring must take place with regard to the environment within which the change is happening.

- *Milestones and targets* will have been set earlier in this stage when detailed plans were being made: their achievement must be checked regularly during the change process. It is also important to adjust these milestones and targets if circumstances change.
- As well as the milestones and targets, it is also important to check if the *anticipated benefits* are accruing – if they are not, it may be that the plan needs to be changed, otherwise those involved will become disillusioned about the change in which they are involved.
- Another aspect of monitoring at this stage is to look for the *impact of the change*, and possible unintended consequences of it. Such effects might be either positive or negative: if positive, those aspects may need to be enhanced and supported further and, if negative, the plan may need to be changed.
- During Stage 1 an analysis of *driving and resisting forces* was made – this analysis should be reviewed periodically, as it may have altered while the change is under way. Once again, if these forces have shifted, the plan may need to be changed.
- The *wider environment* also needs constant monitoring: if there are changes in the context, the plan may no longer be appropriate, so flexibility and further change may be needed.

Stage 3: Refreezing – supporting and reinforcing the new solution

Once the change is judged to be complete, the new way of working needs to be supported and reinforced to ensure it is well embedded throughout the organisation. Making a change such as using the computer during the consultation or going paperless will need ongoing monitoring and support to accommodate the needs of the members of the team.

- *Ongoing support* must continue to be provided: for example, giving detailed clinical system training to those using the system in the consultation to enhance their level of competence.

- The change can be further supported by making it as easy as possible by building in *routine processes*, which may also have positive side effects – an example would be agreeing and setting up electronic templates and protocols; these both make it easier to record clinical data using the system rather than paper, and are also likely to enhance patient care.
- Team members must continue to be *consulted* on progress, and modifications agreed and implemented where necessary – those actually doing the job are usually most aware if the change is 'slipping' for any reason.
- At the planning stage, the desired outcomes and benefits will have been articulated. The team's confidence and sense of achievement will be enhanced if those *outcomes are evaluated* regularly using agreed measures and targets. For example, if one of the desired outcomes was better care for patients with diabetes by using an electronic protocol, measures might be numbers of patients with diabetes with lowered blood pressure.
- There must be *regular feedback* to the team members on such measures of progress. This creates a 'virtuous circle' that is likely to further enhance performance, job satisfaction and feelings of recognition and achievement.

Conclusions

It is clear that change is endemic in the NHS, and nowhere is it more rapid and urgent than in the implementation of new information and communications technology. This paper outlines a number of ways (and there are many more) of approaching new implementations of information technology in the clinical environment, taking into account what is known about supporting people through change. In this environment of rapid change, it is easy to forget that it is *people* who have to implement and use technological solutions. If their needs are not considered and met, the 'solution' will fail.

ACKNOWLEDGEMENTS

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ADDRESS FOR CORRESPONDENCE

Sheila Teasdale
PRIMIS
14th Floor, Tower Building
Division of General Practice
University of Nottingham
University Park
Nottingham NG7 2RD
UK
Tel: +44 (0)115 846 6420
Fax: +44 (0)115 846 6432
Email: sheila.teasdale@primis.nottingham.ac.uk

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